Region IV Partnership Strategic Plan and Recommendations

Submitted to the
Virginia Department of Mental Health,
Mental Retardation and
Substance Abuse Services

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INTRODUCTION

Encompassing the City of Richmond, the capital of the Commonwealth of Virginia, and its metropolitan rural, urban and suburban areas, is Region IV in Central Virginia. Six community services boards (CSB) and one behavioral health authority (BHA) offer mental health, mental retardation and substance abuse services to 1,157,800 residents in 20 counties and 5 cities within Region IV. (See Appendix A.) The Region IV CSBs/BHA include Chesterfield CSB, Crossroads CSB, District 19 CSB, Goochland-Powhatan CSB, Hanover CSB, Henrico Area CSB and Richmond Behavioral Health Authority (RBHA), These CSBs/BHA are responsible for providing public behavioral health and mental retardation services to almost 16% of Virginia's population. Complementing this service array are four state facilities that the Region uses for psychiatric inpatient, geriatric and training center services: Central State Hospital (CSH) for adult mental health and forensic services; Commonwealth Center for child mental health services; Piedmont Geriatric Hospital; and Southside Virginia Training Center (SVTC) for mental retardation services.

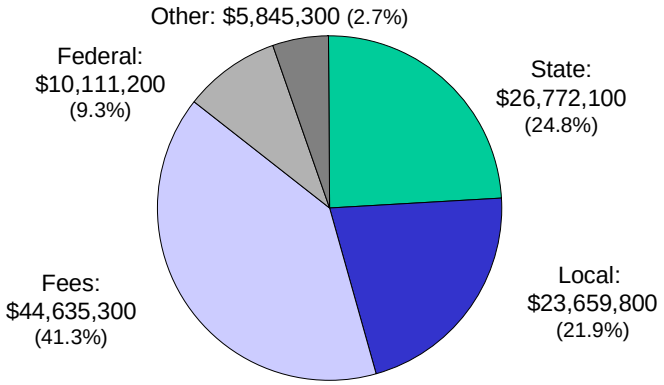
The Region is growing at approximately 1.13%/year, somewhat slower than the average growth in Virginia of 1.33%/year. According to the "Region IV Mental Health Statistical Report," prepared in July 2003 by the Central Virginia Health Planning Agency, Inc. for this Region IV planning effort, the Region's population age distribution mirrors that of the Commonwealth: 28% are youth under 20 years of age; 61% are adults (ages 20 - 64); and 11% are older adults (ages 65 and older). However, Region IV presents a more diverse population composition than does the State as a whole: 36.2% of the Region IV residents are non-White, compared to 27.7% for Virginia. Diversity reaches higher levels in pockets of Region IV, most notably in Richmond where 62% of the population is non-White and in Petersburg, served by District 19 CSB, where the non-White population exceeds 81%. This diversity presents extra challenges for effective service delivery.

Although poverty in Region IV approximates the statewide average, 9.7% for Virginia and 9.3% for Region IV, certain areas substantially exceed these levels. Between 16% and 20% of individuals residing in Crossroads CSB area and in the cities of Petersburg and Richmond live in poverty. Some but not all of these impoverished persons will qualify for Medicaid. Those who do not meet the Medicaid requirements are likely to seek services as indigent persons and comprise the growing number of uninsured or underinsured persons.

Funding for public mental health, mental retardation and substance abuse services comes from a variety of sources: State, local, federal, fees and other payers, as shown in Figure 1. Region IV CSBs/BHA generate 41%, over $44.6 million, of their revenues from fees by billing Medicaid, Medicare, private insurance plans and consumers for services. They receive almost a quarter of their revenues from the State (25% or $26.8 million) and another quarter from

local governments (22% or $23.7 million). The federal government funds 9% of the programs, mainly for substances abuse services. The average regional per capita spending for all services is $95.92, ranging from $78.90 at one CSB to $134.51 at another.

Figure 1. Revenue Sources for All Region IV CSB/BHA Services

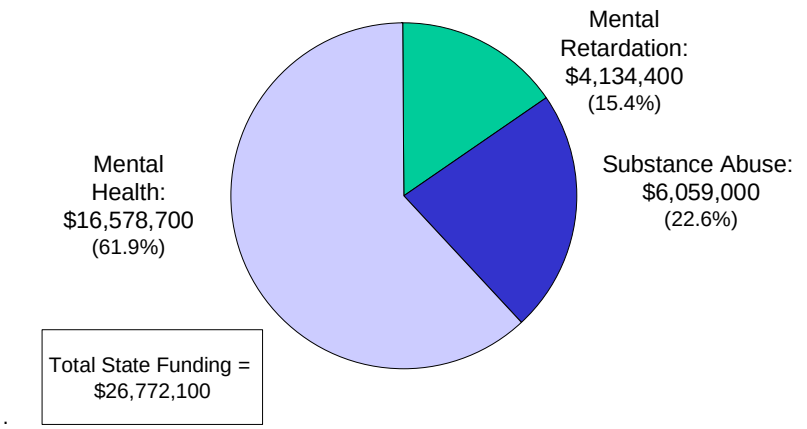


Note: Fees do not include all Medicaid Waiver funds paid to Region IV Providers.
Source: Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

Region IV CSBs and BHA are clearly dependent upon fee generation for funding in each of their service areas. They collect $20.8 million in mental health service fees, $21.6 million in mental retardation service fees, and $2.2 million in substance abuse service fees. A significant amount of fee revenue for mental health and mental retardation may be attributed to Medicaid reimbursements. Since the State Medicaid plan provides only limited reimbursement for substance abuse services, substance abuse fee revenues are considerably less than those for mental health and mental retardation services.

Similarly, state and local funding differ by service areas. State funding, provided by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), accounts for $26,772,100 of the revenues for the Region IV CSBs/BHA. Sixty-two percent (62%) of these funds go to support mental health services at an average rate of $14.70 per capita. Variations in receipt of state per capita funding for mental health services range from $26.87 at one CSB to $7.99 at another CSB. The distribution on state funding is shown in Figure 2.

Figure 2. State Funding for Region IV CSB Services

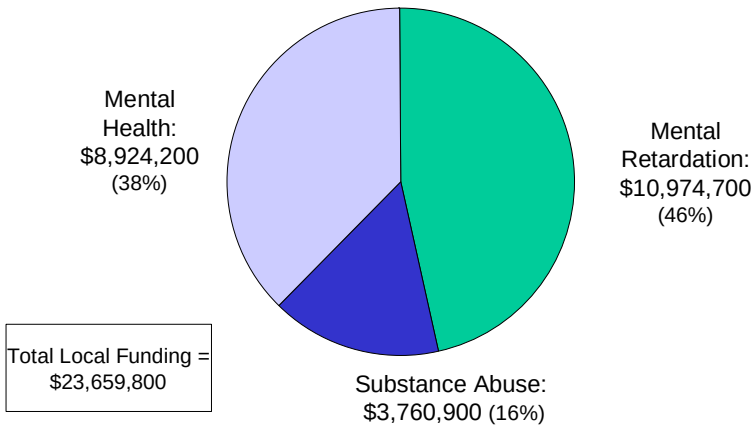


Source: Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

By contrast, most of local funding in Region IV (46.4%) is provided for mental retardation services, followed by funding for mental health services (37.7%) and substance abuse services (15.9%). (These distributions are displayed in Figure 3.) The average per capita local funding ranges from a high of $9.73 for mental retardation to a low of $3.34 for substance abuse services.

Although several factors contribute to disparities in service provision across the region, two are foremost in importance: 1) the amount of local funding a CSB/BHA receives and 2) the number of consumers who are eligible for Medicaid reimbursement. Localities vary extensively in their ability and willingness to fund public behavioral health and mental retardation services, as noted above. At the same time, the CSBs/BHA are becoming more reliant on Medicaid as a revenue source. Some communities have large numbers of consumers who meet the strict Medicaid diagnostic and income eligibility requirements. Other communities, however, have fewer consumers for whom Medicaid will pay for services. These disparities contribute to the confusion on the part of some consumers who think that the service system is completely State funded and that services should be uniform across the Region.

Figure 3. Local Funding for Region IV CSB/BHA Services



Source: Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

The lack of adequate funding and the need to establish additional services is a major recommendation from the participants in this planning process. Similarly, the need for additional resources for community services is also among the major findings of the "Planning District 15 Behavioral Health Task Force Report" of March 2004, prepared by the Central Virginia Health Planning Agency. Five key findings are highlighted in the report:

1. "Inpatient psychiatric care is unusually high in Planning District 15 [that includes the areas covered by Chesterfield, Goochland-Powhatan, Hanover and Henrico Area CSBs as well as RBHA] when compared to other planning districts and Virginia as a whole. [Note that unlike some other areas in the State, Region IV makes extensive use of private hospital inpatient beds for TDOs, temporary detention orders.]
2. The strongest predictors of persons with three or more [psychiatric hospital] admissions during a year include . . .
    - a diagnosis of schizophrenia or bipolar disorder
    - a prior year's hospital history and a higher number of hospital admissions the prior year
    - residence in Richmond, as opposed to the surrounding areas.
3. This significant reliance on local psychiatric inpatient care for this population is closely related to a lack of appropriate alternative community-based support services.
4. Planning District 15 CSBs/BHA have demonstrated successful models of appropriate alternative community-based support services but are hampered by a systemic lack of funding.

5. Resources currently dedicated to inpatients with multiple readmissions could potentially be redirected to proven models of more appropriate alternative care."

State funding for services continues to be limited. Unfortunately, Virginia ranks low among states in per capita funding for behavioral health and mental retardation services. Although the State provides about one-fourth of the funding for services in Region IV and has defined a set of criteria to classify persons as members of priority populations to receive services, the State Code lists only emergency services, case management and prescreening for State hospital and training center admissions as the only required services. Implementing a full range of services is left to the local CSBs/BHA to do as best as they can with the multiple and invariably inadequate funding sources. This arrangement leads to inconsistent service levels across jurisdictions and confusion on the part of consumers.

1. REGIONAL PARTNERSHIP MISSION, VALUES STATEMENT, AND STRATEGIC DIRECTION

Region IV supports the mission statement, values statement and strategic direction proposed by the DMHMRSAS. This includes a focus on self-determination, empowerment and recovery; quality of services; access; accountability; partnerships; coordination; appropriate funding; and efficient use of resources.

2. OVERVIEW OF REGIONAL PARTNERSHIP STRATEGIC PLAN

2-A. Recognition of Regional Partnership (Reinvestment) Accomplishments

The Region IV Consortium (CSB/BHA Executive Directors and CSH and SVTC Directors) has overseen and guided the Region IV Reinvestment Project since planning began in January 2003. The Consortium has accomplished several major goals, including:

- Established an annual DMHMRSAS/CSH/CSB-BHA Reinvestment Memorandum of Agreement with RBHA as Reinvestment Fiscal Agent.
- Identified a Project Manager Position.
- Acknowledged responsibility for intensive utilization management vested in the Regional Authorization Committee (RAC) and for monitoring to be provided by the multi-stakeholder Region IV Partnership Planning Steering Committee.
- Completed Phase I and Phase II Plans that resulted in the closure of 40 civil CSH beds and the transfer of $2.8 million to the CSBs/BHA for reinvested expansion of regional and local consumer services.
- Implemented new/expanded local CSB/BHA services, including specialized group living/day program; assertive community treatment; psychosocial program; intensive case management; medication/support; and specialized individual supervision services.
- Established new regional services: Six-bed Residential Crisis Stabilization/Detox Program that operates 24hours/day, 7 days/week; Behavioral Support Team; Jail/Forensics team serving three targeted jails; and Intensive Individual Consumer Support Service.
- Finished the planning phase for Specialized Nursing Care Services and is pursuing vendor contracts for this service.
- Hired a Project Manager who began working on this project in September 2003.
- Established a quarterly fiscal reporting structure and process.
- Piloted a “Reinvestment Outcomes Quarterly Report,” beginning in the third Quarter of 2003-04.
- Implemented reinvestment so that it enhanced cooperation among CSBs/BHA and CHS.

2-B. Brief Description of the Regional Partnership Strategic Planning Process and Its Participants

The Region IV Partnership Planning Steering Committee was established in January 2003 and is responsible for this planning process. The Committee has been comprised of multiple stakeholders from its inception and has benefited from the insights of the following members:

Steven Ashby*	Richmond Behavioral Health Authority
George Braunstein*	Chesterfield CSB
Michael O'Connor*	Henrico Area CSB
Joe Hubbard*	District 19 CSB
Jim Stewart	Henrico Area CSB
Rose Stith-Singleton*	Parent/Advocate
Carlene Junius	Parent/Advocate
Lynn Brackenridge*	Provider- Gateway Homes of Greater Richmond, Inc.
George Hettrick*	Attorney/Advocate; Henrico Area CSB
Kelly Furgurson*	District19 CSB
Pat Thacker*	Hanover CSB
Stuart Callahan*	Hanover CSB
Beth Rafferty*	Richmond Behavioral Health Authority
Louis Fox*	Henrico Area CSB
Trula Minton*	Provider- CJW Medical Center- Tucker Pavilion
Charles Davis*	Central State Hospital
Larry Latham	Central State Hospital
Vicky Montgomery	Central State Hospital
John Holland	Southside Virginia Training Center
Florence Rhue*	Local Government- City of Petersburg
Eric Campbell	Local Government- City of Petersburg

Note: * refers to current members

In the Spring of 2003 the Committee structured a survey to assess its regional service needs, gaps and priorities. The responses of one hundred fifty (150) regional stakeholders were then used in this planning effort. The Committee then contracted with Central Virginia Health Planning Agency (CVHPA) to conduct a study of demographics, health insurance status, acute care hospital utilization, and inpatient admissions/patient days in Region IV, using data available through 2001. CVHPA presented a report to the Committee in June 2003. In the Fall of 2003 the Committee planned and held two public hearings and five stakeholder focus groups (Mental Health, Substance Abuse, Mental Retardation, Criminal/Juvenile Justice, and Hospitals/Providers). By March 2004 the Committee wrote a report that identified five priority planning initiatives for the Region (mirroring the areas of focus derived from each of the five Fall 2003 focus groups) and summarized its work to that point. Since May 2004 the Committee has focused on developing the Region IV Partnership Planning Strategic Plan as requested by the DMHMRSAS Commissioner.

3. SUMMARY OF THE REGIONAL PARTNERSHIP'S STRATEGIC ASSESSMENT

3-A. Brief Description of Constituent and Consumer Expectations with Documentation, where appropriate

- Quality, appropriateness, responsiveness of services and supports delivered by the CSBs, state facilities and other providers
- Consumer and family member satisfaction with services and supports provided by or through the CSBs, state facilities, and other providers and the availability of choice among providers
- Extent to which consumers and family members have had meaningful involvement in Regional Partnership strategic planning

Region IV used several mechanisms to learn about constituent and consumer expectations. To gain the broadest input, Region IV conducted stakeholder surveys, focus groups and two public hearings. In addition, the responses from 875 consumers who answered survey questions for DMHMRSAS' 2003 Adult Mental Health and Substance Abuse Outpatient Consumer Surveys provide valuable information about consumer satisfaction with services. The Steering Committee members, representing consumers, CSBs/BHA, state facilities, private sector, related public agencies, and specific disability areas, contributed their observations and expertise. While no one approach can completely portray the sentiments of constituents and consumers, these combined efforts allow Region IV to tap several perspectives for service satisfaction and potential areas for improvements.

Outpatient consumers who answered the survey questions for the Mental Health and Substance Abuse outpatient services expressed general satisfaction with the appropriateness of the services they receive and access to those services. Consumers of substance abuse and combined mental health and substance abuse services also indicated general satisfaction with services as well as satisfaction with their service outcomes. By contrast, adults who receive Mental Health Outpatient Services appear to be less satisfied with outcomes related to the services they received. The Region IV survey results are displayed in Table 2.

Table 2. Percent of Region IV CSBS/BHA respondents who report satisfaction with services

	MH Adult OP[1]	SA Adult OP[2]	MH/SA Adult OP[3]
Appropriateness	88.65% (N=505)	86.60% (N=201)	88.93% (N=162)
Access	87.70% (N=509)	80.75% (N=203)	86.56% (N=163)
Outcome	65.87% (N=493)	88.28% (N=199)	77.06% (N=158)
General Satisfaction	NA	87.12% (N=201)	91.05% (N=163)

[1]Includes responses from Chesterfield, Crossroads, District 19, Goochland-Powhatan, Hanover, and Henrico Area CSBs and Richmond BHA.
[2] Includes responses from Chesterfield, Crossroads, and Henrico CSBs and Richmond BHA.
[3] Includes responses from Source: DMHMRSAS Consumer Survey 2003 Annual Report

DMRMRSAS also conducted two other consumer surveys: one to capture satisfaction with mental retardation services, as perceived by family members and guardians; and another survey to assess the satisfaction with children and youth services based on parental responses. Both of these reports are written to reflect statewide, not regional, data.

In preparing their responses to this section of the Plan, the Steering Committee reviewed all the input available to them -- data from surveys, focus groups, public hearings and reports -- and augmented these observations with their own knowledge and experience. The consumer and constituent expectations are presented by service area in terms of satisfaction and dissatisfaction with the quality, appropriateness and responsiveness of services. Addressing these concerns, Region IV then offers several suggestions for changes that would improve services delivery.

Satisfied with quality, appropriateness, responsiveness

Child and Adult Mental Health • PACT teams for adults • Prescreening and diversion as part of the Emergency Commitment Order (ECO)/Temporary Detention Order (TDO) process • Working relationship with court system • Ability to creatively use limited funds • Use of consumer peer supports • "Warm" lines (volunteer phone counseling services)
Mental Retardation • Communication between mental retardation directors and staff throughout the region • Long-term case management • Resource sharing among the regional CSBs/BHA • Good working relationships with private providers • Creative person-centered programming/services
Substance Abuse • Drug Courts • Outpatient services (although some localities have stopped providing these services) • Residential treatment at Turning Point • Adult residential treatment • New regional crisis stabilization unit, scheduled to start in late October • Prevention approaches that are best practice models • Intensive Outpatient Programs for adults • Jail based services
Juvenile Justice • CSBs/BHA assessment/ evaluations • CSBs/BHA crisis intervention services • Outpatient Substance Abuse treatment (when available)
Adult Criminal Justice • Crisis work, especially TDOs • Education of deputies about mental health and substance abuse needs of inmate • Substance abuse services (when available)

Not satisfied with quality, appropriateness, responsiveness

Child and Adult Mental Health

- Lack of funding of services
- Need for greater range of alternatives to inpatient care
- Services often provided along rigidly determined eligibility guidelines that may limit comprehensive treatment planning
- Criticism of management of chronic clients who constantly cycle through service system with no apparent progress
- Lack of prevention services
- Lack of public awareness of existing services

Mental Retardation

- Not enough cross collaboration among professionals, especially MR/MH/SA
- Not enough collaboration between communities and facilities
- MR/MI crisis services that are often not provided well
- Not enough regional planning for challenging, but small, populations
- Executive Directors often not well educated regarding MR populations needs

Substance Abuse

- Budget cuts/ limited funding
- Lack of services for persons with co-occurring disorders
- Lack of Medicaid funding for services
- Practice is too office-based

Juvenile Justice

- More community-based mental health treatment services needed for youth who may benefit from this type of service
- Lack of resources
- Length of time involved in TDO process, e.g., locating beds, transporting consumers
- Lack of CSBs/BHA creativity in designing new services
- Lack of CSBs/BHA mental health services for juvenile sex offenders, juvenile chronic offenders, students expelled form school, children with co-occurring disorders

Adult Criminal Justice

- Not easy for jail personnel to communicate needs/problems of mentally ill to CSB/BHA staff
- Concern about CSB/BHAs' response and intervention with persons with mental illness who do not meet commitment criteria
- Too few mental health resources for an ever increasing number of inmates

Suggested Changes

Child and Adult Mental Health

- Highest priority populations for public services:

1. "Poly-system kids"
2. "Most dangerous" consumers
3. Foster care kids
4. Geriatric population

- Increase eligibility for Medicaid to at least 150% of poverty level

- Highest priority services:

1. Residential as alternative to inpatient
2. "Wraparound" services
3. Greater emphasis on evidence-based practices
4. Services for special populations, including dual diagnosis clients, early diagnosis and treatment (school based), prevention services, and acute care
5. Acute care beds

- Top priorities for change:

1. Increased funding
2. Continue to shift resources to the community, with special emphasis on youth
3. Change Medicaid eligibility requirements
4. Expand Medicaid covered services to include a full range of Best Practice services
5. Need to change State Medicaid practices so that jail inmates/those not guilty by reason of insanity (NGRI) and juvenile detainees may have their Medicaid suspended rather than terminated.

Mental Retardation

- Allow more flexibility with funding
- Allow greater access to training centers and mental health facilities
- Train more psychiatrists in the area of MR/MI
- Require rotations of "in-training" psychiatrists in CSBs/BHA
- Better train crisis staff to handle MR crises more comfortably and independently
- Better train psychologists to evaluate/test persons with mental retardation
- Develop skilled behavioral interventionists who can receive reimbursement
- Increase partnerships with other community resources/services that MR clients could utilize (e.g., senior services, housing services)
- Assure that regulations impacting the disability populations are in harmony rather than contradictory
- Develop advocacy resources for persons not eligible or not receiving Case Management services
- Involve academia (University affiliated facilities and other departments) in developing the workforce

Substance Abuse

- Capacity expansion
- Quicker access
- Need to expand services in
    - residential care
    - life support services, e.g., housing, transportation
    - case management specialized outpatient
- Need to train mental health personnel to identify substance abuse components in persons who present as mentally ill or mentally retarded

Juvenile Justice

- Redesign service system so that youth who cannot benefit from treatment receive the level of services that they are likely to use effectively
- Refine assessment ability to better triage and match effective services to clinical need
- Expand crisis intervention focus to include immediate short-term (2-3 hours) in-home stabilization
- Develop cross-disability and special population service models
- Develop services for adolescents transitioning to adult mental health services

Adult Criminal Justice

- Thorough evaluations to determine who may benefit from mental health services in jails
- Additional substance abuse services in jails
- Post release intensive case management, e.g., PACT
- Substance abuse follow-up in the community
- Legislative change to widen TDO criteria
- Safe housing for persons with long-term mental illness and for persons with substance abuse problems
- Graduated release program with both jail-based and community treatment and monitoring

3-B Brief Description of Regional Partnership's SWOT

Based on information gleaned from surveys, focus groups, public hearings, and extensive experience in service provision, the Steering Committee conducted a SWOT analysis, assessing Region IV's **S**trengths, **W**eaknesses, **O**pportunities and **T**hreats. Responses in each segment of this analysis are categorized to help the reader understand the uniqueness of Region IV.

Strengths are grouped into four categories:

1. Consumer Care
2. Funding
3. Regional Cooperation
4. Service Management

1. Consumer Care
- Local system of care, including presence in each locality
- Local access for consumer input to local CSB and local elected officials
- Mental Retardation, Mental Health and Substance Abuse services systems are working much closer together to identify and serve persons with co-occurring disorders
- Able to place consumers with complex needs in community

2. Funding
- Creative use of funds
- Local and categorical State funding that allows some flexibility in program and service development

3. Regional Cooperation
- Strong regional cooperation among CSBs/BHA and private providers
- Local/State partnership

4. Service Management
- Local single point of access to care
- Single source of case management for priority populations
- Single point of entry into State facilities
- Clear responsibility for "safety net" services
- Local access for consumer input to local CSB and local elected officials
- Regional management of state hospital census
- History among CSBs/RHA, private sector and State facilities of implementing successful projects
- Infrastructure in place to provide care
- Large network of providers in public/private partnerships
- High quality of CSB/BHA employees in Region IV
- Fairly flexible in responding to needs over time
- Helped to bring about independent Virginia Office of Protection and Advocacy

Weaknesses may best be understood as barriers to effective service delivery. These weaknesses are categorized into five groups, including the four categories listed above for Strengths. The subcategories, however, describe a different set of concerns:
1. Consumer Care
2. Funding
3. Regional Cooperation
4. Service Capacity
5. Service Management

1. Consumer Care

- Inconsistent access to array of services from one CSB to another
- As a result of deinstitutionalization, more persons with mental illness requiring an intensive level of community-based services
- New psychotropic medications that cost more and require more staff time to monitor; where older drugs may cost less and have known side effects, the newer drugs are more expensive with side effects that are just becoming apparent.
- Under-recognition and under-reporting of substance abuse problems for persons with mental illness
- Absence of Medicaid for more than half the mental health consumers that means that some consumers may have no access to primary health care

2. Funding

- Lack of inflationary increases
- Infrastructure costs
- Limited funding
- No effective provision to deal with administrative costs
- Anticipate that at some point, costs will become too prohibitive to provide services
- Medicaid Waiver system -- if no Waiver, no service; only funding services for Waiver-eligible persons
- No funding for residential and/or employment services for mental health --no Medicaid, no vouchers
- Increasingly inflexible State funding
- Essential Medicaid match that results in less State funding for services for a large indigent populations that fail to qualify for Medicaid funding
- Over reliance on Medicaid funding

3. Regional Cooperation

- Legal and potential political barriers to creating a regional entity
- Jurisdictional boundaries for services

4. Service Capacity

- Insufficient number of inpatient psychiatric beds that are subject to inappropriate use
- Lack of community crisis care options, in lieu of inpatient services
- Lack of low-cost, adequate housing
- Insufficient number of respite beds
- No transitional services for adolescents moving from youth to adult services
- Lack of a variety of crisis stabilization services options has put excess demand on acute care services
- Insufficient services for aging and medically fragile population
- When went to regional approach, State imposed different admissions standards for CSH, reducing the pool of beds that Region IV may access

- Cannot get people admitted to SVTC behavior unit because admissions are limited for use by people from outside Region IV
- Out of region transfers into the forensics unit reduces the availability of civil beds for Region IV

5. Service Management

- Excessive administrative requirements
- Lack of housing alternatives with effective, trained staff
- Current standards that allow individuals and organizations who are not prepared to run programs to become providers
- Lack of consistent level of services that are required and funded
- Acknowledgement that the majority of youth with serious emotional disturbances who receive services through the CSBs/BHA and/or Comprehensive Services Act (CSA) will not meet the current criteria for classification as SMI (seriously mentally ill) and will not be eligible for priority population services and funding
- Persons with complex issues who sometimes are unable to access private hospitals or nursing home beds are sent to CSH, if mentally ill, and SVTC, if mentally retarded
- CSH designated forensics unit that funnels out-of-region patients into Region IV services
- Issue of using state service match funds to expand Medicaid services instead of providing more indigent care

Opportunities may be classified into four of the five categories used above. Again, the subcategories describe a different set of concerns:

1. Consumer Care
2. Funding
3. Service Capacity
4. Service Management

1. Consumer Care

- Acknowledge better tie of diagnostic evaluation to wider, more effective array of services; may mean minimal treatment and high containment

2. Funding

- Virginia being so far behind other states that they have opportunity to move up in ranking without blazing new trails
- Expanded use of public/private partnerships and regional cooperation that creates economies of scale and increase the supply of services and employment
- Increased use of public/private partnerships that are driven by public interest and public demands

3. Service Capacity
- Opportunities to partner with existing organizations for housing
- Vacated buildings on Dinwiddie campus that may need to be brought up to Code and potentially considered for non-institutionalized uses
- Might assist in establishing consumer business where consumer could work without losing primary Medicaid benefits

4. Service Management
- Potential participation in process exploring system changes for CSA (Comprehensive Services Act)
- Further regional component
- Change State Code to operate differently, i.e., 501(c)3 to qualify for additional funding to help with non-traditional services

Threats fall into three categories:
1. Consumer Care
2. Funding
3. Service Management

1. Consumer Care
- Continual loss of manufacturing and low skill jobs, as well as low-cost housing
- Increasing immigrant population that requires culturally competent and multi-lingual staff that CSBs/BHA do not currently have
- Conflicting licensure and Medicaid regulations requirements
- Inadequacy of Medicaid provider rates
- Anticipated reduction and caps in Section 8 housing
- Criminalization of substance abuse and mental illness
- Lack of inflationary factor regarding public funding allocations and provider rates
- Flat funding over time in spite of inflationary growth
- Virginia as a state that requires a very low poverty level to be eligible for Medicaid, (i.e., applicants may not have more than 80% of poverty income to qualify for Medicaid)
- Large number of indigent persons who are not eligible for Medicaid reimbursement

2. Funding
- Department of Rehabilitative Services (DRS) limitations for persons with mental illness and persons with substance abuse problems to get DRS funding for jobs
- Center for Medicaid and Medicare Services (CMS) cap on Medicaid expenditures and/or complete restructuring of Medicaid
- Growing numbers of uninsured persons, especially for psychiatric care; increased charity care and inappropriate care

- Public and political perception that CSA and children's mental health funds are one in the same, when CSA for mental health services is actually a small portion of MH funding

3. Service Management

- Work force that must be better trained and more diverse
- Current array of services that may not be relevant to culturally diverse consumer populations
- Caregiver staff that will be hard to find in the future, especially psychiatrists
- Emerging expectations to serve unserved and underserved populations without sufficient new resources
- Push by State for community post-offender and gero-psychiatric services without new funding

3-C. Brief Description of Any Emerging External Political, Economic, Social and Technological Trends

Region IV, as other areas of the State, is experiencing several trends that may significantly impact service delivery.

- Medicaid is increasing its dominance as the largest funding stream for the public and private system, while the federal and State governments are looking for ways to limit its growth.
- The current economy and increasing numbers of immigrants has created increased service demand from non-traditional populations.
- Increasing local resistance to the shift of program costs from the State to localities.
- Virginia's one term Governor law leads to wholesale changes in top executive leadership every four years. It encourages inconsistent public policy and discourages risk taking that could potentially lead to creative service development.
- Healthcare economics have discouraged the development or maintenance of acute inpatient units, resulting in chronic bed shortages.
- The increasing number of new psychotherapeutic medications has improved consumers' abilities to live productively in the community, but has also increased the financial burden on the system to pay for these newer treatments.
- While overall information technology has developed so that a paperless system will soon be possible, CSBs/BHA have insufficient capital funds to invest in these improvements.
- The gap between psychiatry and medical services is increasing.
- Fewer doctors elect to work in the public sector.
- Local governments are increasingly resistant to cost shifts from State to localities.

3-D. Brief Description of Opportunities for Achieving Operational Efficiencies and Cost Savings

The criteria below are those factors that Region IV continues to employ when evaluating the use a regional or sub-regional approach for service operations:

- Does not conflict with local system of care
- Does not put local funding at risk
- Improves access or quality of the service
- Increases overall resources expended on services to consumers (economies of scale)
- Creates an overall improvement in the continuum of care by linking services
- Creates a new regional service that cannot be sustained if implemented independently by each CSB/BHA
- Increases efficient use of funding
- Encourages a continued internal and cross institutional review of opportunities to apply reinvestment and restructuring techniques that are consistent with similar approaches being taken in the community

Although Region IV has worked hard to create new or improved services, it recognizes that creativity is no substitute for additional and sufficient funds for services. Currently, Region IV has implemented the following regional services:

- Regional management of census at CHS
- Crisis Stabilization and Dual Diagnosis Detox at Rubicon
- Residential Substance Abuse treatment at Turning Point
- Regional Behavioral Intervention Team
- Regional Jail Services Team
- Acute Mental Health local hospital care

In addition, the following areas already exist as or have the potential to become regional or sub-regional structures:

- Core staff training needs (medication maintenance, behavioral interventions)
- Administrative services (procurement, credentialing, contract negotiations, monitoring acute inpatient bed availability)
- Access to housing
- Access to employment
- MR residential crisis stabilization and short-term residential services
- MR day support
- MR residential treatment
- SA residential treatment
- Opiate replacement therapy
- Medically necessary detox
- After-hours crisis intervention

- In-home services
- Psychosocial services
- Respite services
- Therapies, such as occupational, physical and speech
- Services likely to be contractual, where group purchasing or shared resources are desirable:
    - Services already available regionally or sub-regionally in some form:
        - MR day support
        - MR residential
        - SA residential treatment
        - Opiate replacement services
        - Medical detoxification
        - In-home services
        - Respite services
        - Acute care hospitalization
    - Services not yet available regionally or sub-regionally
        - Therapies, such as occupational therapy, physical therapy, speech therapy
        - Access to employment
- Services that are likely to be directly operated or contractually tied specifically to the region or sub-region:
    - Services already available regionally or sub-regionally in some form:
        - Behavioral intervention services
        - Crisis stabilization
        - Dual diagnosis detoxification
    - Services not yet available regionally or sub-regionally
        - MR residential crisis stabilization and short-term residential services (in planning stage)
        - After hours crisis services
        - Specialized nursing home beds (in planning stage)

4. CRITICAL ISSUES FACING THE REGION

Several critical regional issues emerged through the Region IV Strategic Planning effort to address concerns pertaining to mental health, mental retardation and substance abuse service delivery. These concerns are grouped into four categories:

1. Environmental
2. Funding
3. Service Capacity
4. State Hospital/Training Center

1. Environmental

- Disproportionate share of low income persons in the cities of Richmond and Petersburg and in the Crossroads CSB area
- Lack of adequate public transportation
- Large geographical area
- Criminal and juvenile justice populations
- Population growth

2. Funding

- Lack of inflation factor regarding public funding allocations and provider rates
- Flat or decreasing State and local revenues in the face of increasing client demand
- Limited Medicaid rate increases

3. Service Capacity

- Lack of sufficient housing.
- A situation that aggravates the lack of sufficient housing, e.g., when beds are closed by licensing due to poor management, they are not replaced, in part due to inadequate reimbursement rates
- Disproportionate number of accessible living facilities (ALF) beds in Region IV
- Need for specialized services for a growing immigrant population
- Limited services for Non-Waiver MR consumers
- Rising medication costs
- Safety net services are not the same as Recovery services
- Need to determine the specific role of State institutions as representing the "safety net" for the overall public mental health, mental retardation and substance abuse service system
- Need to apply "reinvestment" approaches and system redesign among institutions within and across regions and statewide in support of community-based system restructuring and redesign
- Large number of providers who are unprepared to meet the needs of the most challenging consumers

4. State Hospital/Training Center

- CHS and SVTC viewed as State, not regional, facilities; management of regional beds impaired by other regions' clients; demand exceeds capacity
- Lack of acute care beds for children
- Official health planning documents that indicate that region has a sufficient number of beds but do not account for out-of-area patients using those beds
- Demand for beds that offsets capacity to meet needs
- Number of uninsured and underinsured patients that is three times the number of CSB admissions into acute care beds

5. STRATEGIC GOALS, OBJECTIVES AND STRATEGIES

The Region IV Restructuring and Strategic Planning Project is part of a two-year planning effort initiated throughout the Commonwealth at the request of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services. In its first year planning efforts, Region IV initiated several reinvestment projects throughout the Central Virginia area. Having successfully planned to close public psychiatric hospital beds and reinvest the money into community services, during the second year Region IV focussed on restructuring services for more efficient and effective delivery throughout the region.

In order to identify potential restructuring projects, Region IV held two public hearings and six focus groups in September 2003. The focus groups were convened to address mental health, substance abuse, mental retardation, local government, criminal/juvenile justice, and hospital/private provider issues. After reviewing the results of these meetings, the Steering Committee asked the focus groups resource persons to propose one or more resturcturing projects for implementation. The details of the proposals are included in the exerpts from the "Region IV Restructuring and Strategic Planning: All-Day Planning Session" report, found in Appendix B.

The Steering Committee engaged the services of a consultant to organize the data from the proposals, to conduct an all-day planning session, to select proposals for implementation, and to prepare a brief report of the planning session. The consultant created and distributed a questionnaire to the resource persons, who provided preliminary information about each proposal and addressed the selection criteria that the Steering Committee adopted at its November 2003 meeting. These criteria include:

- Will require no new money [a criteria set in November 2003 that was no longer operable by March 2004]
- Resolves confusion/dysfunction
- Regional in nature and/or moves system toward greater consistency across CSBs/facilities
- Identified as greatest need - defined as
    - no place for treatment
    - need for greater capacity
    - lack of advocacy
    - most vulnerable population demand exceeds capacity more so than in other areas
- Will have an impact on more than one disability area
- Other factors:
    - enable greater efficiency
    - is proactive/early intervention program
    - has potential for movement.

Using these criteria, the Steering Committee and resource persons endorsed three projects for implementation:

- Mental Retardation: Emergency beds at SVTC
- Substance Abuse: Residential SA referrals to Turning Point
- Criminal/Juvenile Justice: Self-contained SA treatment in jail.

In addition, they approved two other projects in concept, suggesting further study before implementation begins:

- Mental Health: Alternatives to inpatient care for adults and/or children
- Hospital/Private Provider: Private/public sector coordination of care.

These projects are summarized in Table 3.

Table 1. Summary of Proposed Restructuring Projects

	Focus Group	Proposed Project	Requires New Money	Resolves Confusion/ Dysfunc-tion	Regional/ Greater Consis-tency	Greatest Need	Multiple Disability Areas	Other Factors
Endorsed for Implementation								
1	Mental Retardation	Emergency beds at SVTC for Region IV's most challenging individuals	Yes, including Medicaid Waiver slots for persons being discharged; other funds unknown at this time	Yes	Yes	Yes	Yes MR/MI, MR/Behavioral challenges, MR w/ medical issues	Yes Region will have "reserved" beds, managed cooperatively by the Region and will share Waiver slots
2	Substance Abuse	Residential SA referrals for Turning Point	Yes, including SA Region IV Block Grant	Yes	Yes	Yes	Yes Dually Diagnosed population	None
3	Criminal/ Juvenile Justice	Self-contained SA treatment re: social learning recovery model	Yes, including possibly using inmates' canteen funds	Yes	Yes	Yes	No	None
Approved In Concept; Further Study Needed								
4	Mental Health	Alternatives to inpatient care for adults and/or children with focus on subacute crisis stabilization and supervised living	Yes Amount unknown; possibly Medicaid reimbursement or reinvestment funds	Yes	Yes	Yes	Yes MH patients who seldom carry single disability diagnosis	Yes Reduce dependency on inpatient care; added resources for children re: prevention
5	Hospital/ Private Providers	Private/public sector collaboration for coordination of care	No	Yes	Yes	Yes	Yes MH, SA multiple physical health problems	Yes Enhanced efficiency and proactive treatment

6. REGIONAL RECOMMENDATIONS FOR STATE-LEVEL ACTION

1. During the course of this strategic planning effort, participants noted that the types, quantity and quality of services vary across the Region IV CSBs/BHA. This variance also extends to the populations served by each CSB. As a result of these differences and its concomitant lack of uniformity, consumers may experience barriers to continuity of care when they relocate to another area. These disparities lead to a great deal of public confusion about CSB services in general. To address these issues, the Regional Strategic Planning Partnership adopted a goal of prioritizing populations groups and working toward uniform service availability across jurisdictions. Region IV proposes to use additional regional or local funding to move in this direction.

2. Certain benefits and services should be universal. When and if additional resources become available, a second level of service could be implemented for consumers within the region. A third level of service may be created when localities use their local tax dollars to support certain services for their constituents. While this may result in disparities across the region, residents in specific areas may access additional and often needed services.

3. The State should adequately fund a minimal level of services to assure consistent services throughout the region.

4. DMHMRSAS needs to work with the Department of Medical Assistance (DMAS) so that Medicaid supports services that Mental Health deems essential for recovery. Medicaid must be revamped to become more flexible.

5. The service system must be responsive to the need of persons who have Medicaid as a payer as well as those who do not.

6. DMHMRSAS should seek simplification in administrative processes and reporting.

7. The system needs a more coordinated approach at the State level, one that supports a single vision for a system of care.

8. DMHMRSAS leadership is essential in defining short- and long-term role of State facilities.

9. Facilities should be encouraged to put in practice reinvestment and restructuring concepts that complement and support those in the local system.

APPENDIX A: REGION IV PROFILE

Community Services Boards/Behavioral Health Authority:

CSB/BHA	Planning District	Serving
Chesterfield CSB	15	Chesterfield County
Crossroads CSB	14	Amelia, Buckingham, Charlotte, Cumberland, Lunenberg, Nottoway, and Prince Edward Counties
District 19 CSB	19	Dinwiddie, Greensville, Prince George, Surry, and Sussex Counties; Cities of Colonial Heights, Emporia, Hopewell and Petersburg
Goochland-Powhatan CSB	15	Goochland and Powhatan Counties
Hanover CSB	15	Hanover County
Henrico Area CSB	15	Charles City, Henrico and New Kent Counties
Richmond BHA	15	City of Richmond

Regional Use State Facilities:

Central State Hospital for Adult Mental Health and Forensics services, in Petersburg, Va.

Commonwealth Center for Child Mental Health services, in Stanton, Va.

Piedmont Geriatric Hospital, in Burkeville, Va.

Southside Virginia Training Center for Mental Retardation services, in Petersburg, Va.

APPENDIX B: DETAILS OF PROPOSED PROGRAMS

Excerpts From "Region IV Restructuring and Strategic Planning: All-Day Planning Session"

1a. Region IV/SVTC Emergency Bed Pilot Project for Persons with Mental Retardation and 1b. "Hotel IV" for Persons with Mental Retardation

Title for Proposed Project: Region IV/SVTC Emergency Bed Pilot Project

Name of Focus Group Submitting Proposal: Region IV Mental Retardation

Proposal Prepared by: Patricia Thacker (Resource Person)

Resource Person Contact Information:

Telephone Number: 804 -365-4271

E-Mail Address: **pathacker@co.hanover.va.us**

1. What is the target group for your proposed project?

   Adults with mental retardation who, because of challenging behaviors and non-response to a variety of supports, can no longer remain at home or in a public or private residential facility in the community.

2. What type of service(s) is being proposed?
   a. Two permanent, "reserved" emergency beds at SVTC on the Behavioral Unit, one for a female, one for a male.
   b. Use of one of the empty cottages, plus limited staff support from SVTC behavioral, clinical and medical staff.

3. Please write a brief description of your focus group's proposed project.

   (a) Region IV and SVTC propose to "reserve" two beds on the Behavioral Unit – one for a male, and one for a female. These beds shall be available to individuals when all local resources have been tried, including, but not limited to, the Region IV Reinvestment Project Behavioral Team, the Central State Behavioral Team, emergency placement at Rubicon, regular local "TDOs," in-home services and other local behavioral efforts.

   The Region IV MR Directors shall manage admission and Discharge from these beds. Region IV MR Directors shall pool several Waiver slots for this project (details not yet worked out). This pool of slots will guarantee that the individual will be able to be discharged when an appropriate bed in the community is located. Prior to any admission, the admitting CSB must guarantee that it will replenish the Waiver slot pool, either immediately, or as soon as their next slot becomes available. This will guarantee that the project can continue, and that SVTC will not be forced to keep an individual because there was no funding in the community for a placement.

   (b) Region IV and SVTC propose to use an empty, on-grounds cottage for individuals who need to be away from their community residence for a short time because of behavioral challenges, but who do not need the intense structure of the Behavioral Unit. SVTC will provide room, board, nursing, psychiatric, psychological, and other services as needed. Each CSB will provide 24 hour staffing.

Currently, CSBs use a variety of settings in these instances, ranging from in-home or residential respite to motel rooms in order to remove the individual from his or her main living environment and to provide a different location in which to provide services and supports. Generally, when the behaviors are severe, these settings are not appropriate. Nor do they have the types of supports available that could be provided by SVTC on a limited basis.

4. *The Steering Committee hopes to implement projects without requesting additional funds. What are the funding implications for this project?*

____ The project will not require new money.
__XX__ The project will require new money, estimated to be $_____Unknown__

If the project requires new money, which funding source(s) do you propose to use?

The "reserved bed" project will require Waiver slots. We propose that DMHMRSAS set aside a number of new Waiver slots for this project.

The cottage project will require funding for CSB staff coverage, transportation and expenses, as well as for those services or supports which cannot be provided by SVTC or reimbursed by Medicaid or other third-party payments.

Funding would be needed to provide training for local staff or family members to be able to work with the individual once he or she returns home. Funding might also be needed for such things as respite care in facilities such as Camp Baker as a "step down" from the above projects.

5. *Will this project resolve confusion or dysfunction?*

____ No, the project will not resolve confusion or dysfunction.
XX____ Yes, the project will resolve confusion or dysfunction.

If you answered yes, briefly explain how confusion/dysfunction will be resolved.

This project will help eliminate two dysfunctions in the current system: (1) the inability to admit someone to SVTC because of lack of bed space and (2) the inability to discharge an individual from SVTC because of lack of a Waiver slot. The above problems will not be resolved, but will be lessened.

6. *Is this project regional in nature and/or does it move the system toward greater consistency across CSBs/facilities?*

____ No, the project is not regional nor will it move the system toward greater consistency across CSBs/facilities.
__XX__ Yes, the project is regional or will move the system toward greater consistency across CSBs/facilities.

If you answered yes, briefly explain how regionalization or greater consistency will be achieved.

The project is definitely regional in nature. This will be the first time that Region IV will share its Waiver slots, guaranteeing the continuation of the project. The Region IV MR Directors will manage the project together, making decisions as to admissions and

discharges to and from the reserved beds. The MR Directors and SVTC staff will be working together, guided by specific procedures, moving the system toward greater consistency. In addition, the MR Directors and SVTC staff will also be working closely and consistently with CSB MH staff for those individuals whose behavioral issues are related to a mental health diagnosis or episode.

7. *Does the project address the greatest need, defined as no place for treatment; need for greater capacity; lack of advocacy; most vulnerable population; or demand exceeds capacity more so than in other areas.*

____ No, the project will not address the greatest need.
_XX___ Yes, the project will address the greatest need.

If you answered yes, briefly explain how the greatest need will be addressed.

At the mental retardation focus group on September 26, 2003, one of the top priority consumer populations identified was "Co-occurring MR/MI." Among the priorities listed for needed services were "Crisis stabilization," and "Specialized MR/MI services (diagnostic, treatment, etc)". The top need for system-change was "The Training Center needs to change its focus – be more community-based, need to address emergencies (acute beds)".

The two aspects of this project clearly address these issues.

8. *Will the project have an impact on more than one disability area?*

____ No, the project will not have an impact on more than one disability area.
XX___ Yes, the project will have an impact on more than one disability area.

If you answered yes, briefly explain how the project will have

This project will have a positive impact on individuals with mental retardation and mental illness.

9. *Will the project address other factors, such as enabling greater efficiency; being proactive/ early intervention; or having potential for movement?*

____ No, the project will not address these other factors.
_XX___ Yes, the project will address these other factors.

If you answered yes, briefly explain how these other factors will be addressed.

This project, if successful, may lead to a greater number of "reserved" beds because of the guarantees of discharges. It may lead to SVTC, and/or other facilities, providing more accessible and productive respite care rather than long-term residential services. It may lead to a system where more individuals are provided services because of the guaranteed discharge. In addition, the project is easily replicable throughout the state.

10. *If this project is selected for implementation, what impact do you anticipate this project will have on consumers and services throughout the region?*
    a. More individuals will receive services that will help them remain in the community.
    b. More caregivers will be able to maintain their family members in their homes for longer periods of time.

c. More providers will be able to adequately support the individuals in their care. SVTC staff will be able to share their expertise with a greater number of individuals – a very cost effective use of resources.
d. More persons with a dual diagnosis will receive appropriate services.

2. Substance Abuse

Title for Proposed Project: Workgroup to resolve issues with Turning Point

Name of Focus Group Submitting Proposal: Substance Abuse

Proposal Prepared by: Stewart Callahan (Resource Person)

Resource Person Contact Information:

Telephone Number: __804-365-4240__ __ Ext : __ __ __ __

E-Mail Address: swcallahan@co.hanover.va.us

1. *What is the target group for your proposed project?* Residential SA referrals for Turning Point

2. What type of service(s) is being proposed? Continued funding for SA residential care

3. *Please write a brief description of your focus group's proposed project*.

   See Focus Group Notes attached

4. *The Steering Committee hopes to implement projects without requesting additional funds. What are the funding implications for this project?*

   ____ *The project will not require new money.*
   ____*X The project will require new money, estimated to be $*
   _____*$150,000*_____

   If the project requires new money, which funding source(s) do you propose to use? SA Region IV Block Grant

5. *Will this project resolve confusion or dysfunction?*

   ____ No, the project will not resolve confusion or dysfunction.
   __X__ Yes, the project will resolve confusion or dysfunction.

   If you answered yes, briefly explain how confusion/dysfunction will be resolved. Prevent closing of a Regional Program

6. *Is this project regional in nature and/or does it move the system toward greater consistency across CSBs/facilities?*

   ____ No, the project is not regional nor will it move the system toward greater consistency across CSBs/facilities.
   ___X_ Yes, the project is regional or will move the system toward greater consistency across CSBs/facilities.

If you answered yes, briefly explain how regionalization or greater consistency will be achieved. All region IV CSBs use Turning Point for the SA adult treatment services

7. *Does the project address the greatest need, defined as no place for treatment; need for greater capacity; lack of advocacy; most vulnerable population; or demand exceeds capacity more so than in other areas.*

____ No, the project will not address the greatest need.
___X_ Yes, the project will address the greatest need.

If you answered yes, briefly explain how the greatest need will be addressed. Shortage of SA residential beds

8. *Will the project have an impact on more than one disability area?*

____ No, the project will not have an impact on more than one disability area.
___X_ Yes, the project will have an impact on more than one disability area.

If you answered yes, briefly explain how the project will have an impact on more than one disability area.
Workgroup will directly address the needs of the dually diagnosed

9. *Will the project address other factors, such as enabling greater efficiency; being proactive/ early intervention; or having potential for movement?*

__X__ No, the project will not address these other factors.
____ Yes, the project will address these other factors.

If you answered yes, briefly explain how these other factors will be addressed.

10. *If this project is selected for implementation, what impact do you anticipate this project will have on consumers and services throughout the region?* Will have direct impact on SA adult services at Turning point or the diversion of SA block grant money into other suggested regional programs.

Region IV SA Focus Group

9/24/03

Consumer Population (top two) to focus services on
SA Adolescent/ dually diagnosed
Inmate Offender (SA)
Families of SA
SMI substance abusing population
Women/ children who haven been removed from the family
Families of SA
Adolescent with long term care needs
Consumers in rural areas

Priority Services for the public sector (top three)
Outpatient services for Adults/ Adolescents
1. Intensive
2. Family, Individual, and Case Management driven

3. Aftercare structured
4. Culturally specific
5. Targeted approaches to specialized populations (example- dealers)

Residential treatment
1. Halfway house
2. Therapeutic Community, LT adolescent/adult care
3. Private/non profit model (such as the Healing Place)
4. Detoxification services

Life Support Services
1. Housing
2. Transportation
3. Employment
4. Shelter
5. Case Management

Accessible opiate replacement treatment
Illegal Prescription Drug Use
Linkage from detox to treatment

Regional Establishments (top three)
Capacity expansion/ quicker access
Regional strategies in order to connect agencies with CSBs

Contracted approaches to deal with Opiate replacement and residential Services
Family approaches for the region
Regional needs assessment that addresses resource deployment based on population

Services CSBs should stop (not ranked)
CSBs' being the manager of care for methadone services (payee for methadone care)
Individualized (CSB) approaches for Opiate replacement, detox, and treatment services
Stop being so reactive
Stop creating systems where consumers simply shop across CSB boundaries (such as Henrico offers more money for Opiate replacement then Goochland)

Services CSBs should start (not ranked)
Utilization of mobile treatment services
Regional manager of Opiate Services
Support of facilities like the Healing Place
Agreeing on Protocol for services
Increase State and other funding sources- not just rely on local funding
Unlimited funding for Opiate Replacement
Stimulate cost assessable packages- negotiate across CSB lines services that are costly

Services CSBs should continue
Drug Courts
Outpatient Services (some localities have stopped these service)
Residential Treatment at the Turning Point
Adult Residential Treatment
New Crisis Regional Stabilization Unit (starting in late October)
Prevention using a best practice model

The SA directors met on 12/16/04 to discuss the priority needs of the Region that were of mutual concern. Three issues emerged:

A) Regional residential program known as Turning Point
B) Developing regional wrap around services for Opiate addiction
C) Developing flexible regional purchasing agreements.

Region IV will develop a task force to examine the Regional needs and funding that Turning Point requires. Further developing the TP model of care and utilizing it's services regional will meet many of the needs identified in the focus group.

Wrap around services for the Opiate addicted is another area that is worthy of development. Individual CSBs currently attempt to deal with the issues with limited success. Opiate addicted clients either fall through the cracks or wonder from CSB to CSB seeking services. Region IV could develop a wrap around service model to address these needs on a local level.

Finally the Region could examine its current mechanism of the purchase of certain services and use the power of the region to reduce the cost of services. A goal of the region is to further examine the ideas of regionally purchasing services as oppose to individual CSBs' negotiating brokered services.

3a. Adult Criminal Justice and 3b. Juvenile Justice

Title for Proposed Project: Recovery In A Secure Environment

Name of Focus Group Submitting Proposal: Criminal/Juvenile Justice

Proposal Prepared by: Louis Fox, Psy.D. and Beth Rafferty (Resource Persons)

Resource Person Contact Information:

Telephone Number: 804-501-4590

1. *What is the target group for your proposed project?*

   The target population is substance dependent inmates housed in jails participating in the Region IV Jail Team project. The base rate for substance abuse problems in these jails Is estimated to be 75%.

2. *What type of service(s) is being proposed?*

   A self-contained substance abuse treatment program based on Henrico County jail's social learning recovery model programs. The introductory six-week Intensive Addictions Focus program would be the pilot project.

3. *Please write a brief description of your focus group's proposed project.*

   The Intensive Addiction's Focus program is self-help recovery program based on 12 Step principles, social learning theory and cognitive-behavioral strategies. One entire living area (dayroom, POD) in each participating facility would be restricted to inmates who volunteer to participate in a self-help recovery program. The community should range from 20 to 40 inmates. The program is clinician developed, monitored and revised. The inmate community is responsible for maintaining the daily schedule, supporting each other's recovery and suggesting changes in the program. Scheduled activities (AA/NA meetings, community meetings, educational films, workbook and other written assignments) run 14 hours a day. The Henrico County Sheriff's Department will provide a program description, schedule of activities and a list of resource materials. A small group of inmates who demonstrate a strong interest in the program will be temporarily transferred to Henrico County Jail to complete the Intensive Addictions Focus program.

They will return to their facility to provide leadership as senior members in the new program. The Henrico County Jail Mental Health/Substance Abuse staff will provide consultation to the project site(s) clinical staff (Regional Jail Team staff or other clinical staff designated by the project site Sheriff/Superintendent).

4. *The Steering Committee hopes to implement projects without requesting additional funds. What are the funding implications for this project?*

____ *The project will not require new money.*
__X__ *The project will require new money, estimated to be $10,000*

If the project requires new money, which funding source(s) do you propose to use?

Clinical staff supervising the program will come from staff hired by the Regional Jail Team or existing staff designated by the Sheriff or Superintendent. Approximately $10,000 will be needed annually to purchase educational material and supplies (television, VCR, tape player, films, workbooks, copying). These materials can be purchased through the inmates' canteen funds.

5. *Will this project resolve confusion or dysfunction?*

____ *No, the project will not resolve confusion or dysfunction.*
X Yes, the project will resolve confusion or dysfunction.

If you answered yes, briefly explain how confusion/dysfunction will be resolved.

Both correctional and law enforcement personnel participating in the focus group Identified the lack of substance abuse services as the biggest unmet need. A single dayroom providing services to 30 inmates could provide very low cost treatment to approximately 200 substance dependent inmates a year. Potential benefits of the program include decreasing recidivism, decreasing jail management problems and increasing the contact between the jail and local CSB through referrals of program participants.

6. *Is this project regional in nature and/or does it move the system toward greater consistency across CSBs/facilities?*

____ *No, the project is not regional nor will it move the system toward greater consistency across CSBs/facilities.*
X Yes, the project is regional or will move the system toward greater consistency across CSBs/facilities.

If you answered yes, briefly explain how regionalization or greater consistency will be achieved.

The project is regional in nature as any facility participating in the Region IV Jail Team could participate. Participating facilities will move toward providing a baseline of substance abuse and mental health services provided by other jails in the region.

7. *Does the project address the greatest need, defined as no place for treatment; need for greater capacity; lack of advocacy; most vulnerable population; or demand exceeds capacity more so than in other areas.*

____ *No, the project will not address the greatest need.*

X Yes, the project will address the greatest need.

If you answered yes, briefly explain how the greatest need will be addressed.

This was identified as the greatest need in the Region IV jails. The participants stated that the need ranged from no services provided to demand far exceeding capacity.

8. *Will the project have an impact on more than one disability area?*

__X__ No, the project will not have an impact on more than one disability area.
____ Yes, the project will have an impact on more than one disability area.

If you answered yes, briefly explain how the project will have an impact on more than one disability area.

This is a qualified "No" as many participants will have both mental health and substance abuse problems.

9. *Will the project address other factors, such as enabling greater efficiency; being proactive/ early intervention; or having potential for movement?*

__X__ No, the project will not address these other factors.
____ Yes, the project will address these other factors.

If you answered yes, briefly explain how these other factors will be addressed.

10. *If this project is selected for implementation, what impact do you anticipate this project will have on consumers and services throughout the region?*

The project will provide services to a very underserved population (substance dependent inmates). A successful replication of the program in at least one other facility will increase the possibility of substance abuse services being provided in other jails in the region. If successful, the program may strain the capacity of outpatient substance abuse services in some localities through increased referrals.

4a. Adult Mental Health and 4b. Children's Mental Health

Title for Proposed Project:

Name of Focus Group Submitting Proposal: Mental Health Adult and Children

Proposal Prepared by: Kelly Fergurson (Resource Person)

Resource Person Contact Information:

Telephone Number: 804 -862 - 8003 Ext : 3060

E-Mail Address: kfurgurson@d19csb.com

1. *What is the target group for your proposed project?*

Mental Health Population – adults and children

2. *What type of service(s) is being proposed?*

   Additional alternatives to inpatient care for adults and/or children.

   Restructuring of existing services to allow for comprehensive services which could be developed based on clinical needs and not bound by funding streams, or other limitations currently imposed by the way our system of care is designed.

3. *Please write a brief description of your focus group's proposed project.*

   Sub acute crisis stabilization – for children and adults

   Supervised living – residential services for children and adults. Some of these services would require statutory and regulatory changes that would provide for/allow locked, or otherwise "controlled" residential facilities.

4. *The Steering Committee hopes to implement projects without requesting additional funds. What are the funding implications for this project?*

   ____ *The project will not require new money.*
   ____ *The project will require new money, estimated to be $* _____

   If the project requires new money, which funding source(s) do you propose to use?

Some portion of the proposed projects could be paid for by reallocation funds currently allocated to facility care (A continuation of the reinvestment concept). Some additional services are already reimbursed by third party provider – Medicaid –revenue from such sources might be sufficient to wholly support the service. This hypothesis what based somewhat on the assumption that Virginia will have to broaden the percentage of the population which qualifies for Medicaid.

5. *Will this project resolve confusion or dysfunction?*

   ____ *No, the project will not resolve confusion or dysfunction.*
   __*X*__ *Yes, the project will resolve confusion or dysfunction.*

   If you answered yes, briefly explain how confusion/dysfunction will be resolved.

The project(s) would provide for a more seamless system of care and would reduce the states dependency on the most expensive, least efficient care alternative – inpatient services

6. *Is this project regional in nature and/or does it move the system toward greater consistency across CSBs/facilities?*

   ____ *No, the project is not regional nor will it move the system toward greater consistency across CSBs/facilities.*
   __X__ *Yes, the project is regional or will move the system toward greater consistency across CSBs/facilities.*

   If you answered yes, briefly explain how regionalization or greater consistency will be achieved.

Regional services of this type will increase the availability of alternative services for all members of the region. Services that would not otherwise be available for smaller boards with fewer resources would then be available to them.

7. *Does the project address the greatest need, defined as no place for treatment; need for greater capacity; lack of advocacy; most vulnerable population; or demand exceeds capacity more so than in other areas.*

____ *No, the project will not address the greatest need.*
_X___ *Yes, the project will address the greatest need.*

If you answered yes, briefly explain how the greatest need will be addressed.

The projects will address the greatest need because they are directed at the portions of the patient population who would otherwise require treatment in our most restrictive, most expensive level of care. They are the patients who require the most intensive levels of treatment and who, if untreated, pose the greatest risk to themselves and the general population.

8. *Will the project have an impact on more than one disability area?*

____ *No, the project will not have an impact on more than one disability area.*
_X___ *Yes, the project will have an impact on more than one disability area.*

If you answered yes, briefly explain how the project will have an impact on more than one disability area.

The patients who otherwise end up in our facilities patients who seldom carry single disability diagnosis.

9. *Will the project address other factors, such as enabling greater efficiency; being proactive/ early intervention; or having potential for movement?*

____ *No, the project will not address these other factors.*
_X___ *Yes, the project will address these other factors.*

If you answered yes, briefly explain how these other factors will be addressed.

Reducing dependency on inpatient level care will reduce costs. Added resources devoted toward the care of children will assist prevention efforts.

10. *If this project is selected for implementation, what impact do you anticipate this project will have on consumers and services throughout the region?*

Reduced admission rates for inpatient facilities. Reduced length of stay for inpatient population. Possible reduction in criminal justice system for this population.

5. Hospital/Private Providers

Title for Proposed Project: Collaboration of Care

Name of Focus Group Submitting Proposal: Facility/Provider

Proposal Prepared by: Trula Minton (Resource Person)

Resource Person Contact Information:

Telephone Number: _804-_ __ __ -323-8257 __ __ __ - __ __ __ __ Ext : __ __ __ __

E-Mail Address: trula.minton@hcahealthcare.com

1. *What is the target group for your proposed project?*

   Adults with chronic, serious mental illness and dual diagnoses (primarily, mental illness and substance abuse).

2. *What type of service(s) is being proposed*?

   Structure/mechanism for private sector and public sector collaboration for coordination of care for clients.

3. *Please write a brief description of your focus group's proposed project*.

   Adequate numbers and types of community services and supports are necessary for clients to remain active members of the community; therefore, coordination of care through collaboration of services and care management are necessary to ensure the Client receives the level of service required to keep he/she in the community. The goal of the client's treatment/intervention is to maintain he/she outside of the acute care hospital, while ensuring that if hospitalization does occur, it's aim is to have the patient remain in the community where the CSB and facility can collaborate to provide the services necessary to decrease inpatient length of stay.
   A formal structure for collaboration is necessary to ensure that bureaucratic systems do not impede the access to the appropriate services that the client requires.

4. *The Steering Committee hopes to implement projects without requesting additional funds. What are the funding implications for this project?*

   _X___ *The project will not require new money.*
   ____ *The project will require new money, estimated to be $* _____

   If the project requires new money, which funding source(s) do you propose to use?

5. *Will this project resolve confusion or dysfunction?*

   ____ *No, the project will not resolve confusion or dysfunction.*
   _X___ *Yes, the project will resolve confusion or dysfunction.*

   If you answered yes, briefly explain how confusion/dysfunction will be resolved.

The system for collaboration of care is written and delineated for each jurisdiction (CSB, other governmental agencies) with that of the local acute care facility and provider network to provide access to services on a preventative basis as well as post-discharge to decrease the possibility of readmission.

6. *Is this project regional in nature and/or does it move the system toward greater consistency across CSBs/facilities?*

   _____ *No, the project is not regional nor will it move the system toward greater consistency across CSBs/facilities.*
   _X___ *Yes, the project is regional or will move the system toward greater consistency across CSBs/facilities.*

   If you answered yes, briefly explain how regionalization or greater consistency will be achieved.

   As in #5 above; formalization of the service access structure and communication processes will allow maximization of personnel and community resources so that the patient's identified needs are met.

7. *Does the project address the greatest need, defined as no place for treatment; need for greater capacity; lack of advocacy; most vulnerable population; or demand exceeds capacity more so than in other areas.*

   _____ *No, the project will not address the greatest need.*
   X____ *Yes, the project will address the greatest need.*

   If you answered yes, briefly explain how the greatest need will be addressed.

   It will address the most vulnerable population but will not so for the demand and need for more acute inpatient beds or amount/type of community services (housing, employment, outpatient treatment).

8. *Will the project have an impact on more than one disability area?*

   _____ *No, the project will not have an impact on more than one disability area.*
   _X___ *Yes, the project will have an impact on more than one disability area.*

   If you answered yes, briefly explain how the project will have an impact on more than one disability area.

   Those with chronic mental illness and those with the co-morbidity of substance abuse, many of whom have multiple physical health problems and disabilities.

9. *Will the project address other factors, such as enabling greater efficiency; being proactive/ early intervention; or having potential for movement?*

   _____ *No, the project will not address these other factors.*
   __X__ *Yes, the project will address these other factors.*

   If you answered yes, briefly explain how these other factors will be addressed.

   Enhanced efficiency and proactive treatment are gained by the collaboration for the coordination of care of the client and access to community services (including outpatient treatment, crisis stabilization, etc.).

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10. *If this project is selected for implementation, what impact do you anticipate this project will have on consumers and services throughout the region?*

    Prevention of acute inpatient hospitalizations for many clients whose symptoms become exacerbated and resources are not available other than acute inpatient care to stabilize the person (i.e., the collaboration of
    care and availability of crisis stabilization access would prevent many acute inpatient admissions).

HPR 4 STRATEGIC PLAN – CENTRAL VIRGINIA

Strategic Goals, Objectives and Strategies:

Goal #1: Implement a Region IV/SVTC Project

1. **Implement a Region IV/SVTC Emergency Bed Pilot Project for persons with mental retardation**.
    a. Maintain two permanent "reserved" emergency beds (one male and one female) at SCTC on the Behavioral Unit to provide intensive services when other local behavioral efforts have not worked
    b. Regionally manage admissions from and discharges from these emergency beds
    c. Regionally pool several Waiver slots to guarantee that individuals will be able to be discharged when an appropriate community bed is located.
2. **Establish a Regional Cottage in an empty on-grounds cottage at SVTC so individuals can be moved from their community residence for a short time to address behavioral challenges.**
    a. Through each CSB, provide 24 hour staffing and transportation and expenses.
    b. Through SVTC, provide limited staff support from its behavioral, clinical, and medical staff.
3. **Train local staff and family members to work with individuals when they return home.**
4. **Provide funding for respite care in facilities such as Camp Baker as a "step down" from these projects.**

Goal #2 Maintain Turning Point as a Regional Program.

1. **Establish a workgroup to resolve issues with Turning Point and provide additional SAPT block grant funding to Turning Point.**
2. **Develop regional wrap-around services for opiate addiction.**
3. **Develop flexible regional purchasing agreements.**

Goal #3 Develop self-contained SA treatment in jails

1. **Establish, as a pilot project, a six-week Intensive Addictions Focus program based on the Henrico County jail's social learning recovery model programs.**
    a. Dedicate one entire living area (dayroom, POD) in each participating facility for inmates who volunteer to participate in a self-help recovery program.

b. Receive program description, schedule of activities, and list of resource materials from the Henrio County Sheriff's Department.

c. Temporarily transfer a small group of inmates who demonstrate a strong interest in the program to the Henrico County Jail to complete the Intensive Addictions Focus program and return to their facilities to provide leadership as senior members of the new program.

d. Arrange for the Henrico County Jail to provide consultation to the project's clinical staff.

Goal #4 Study alternatives to inpatient care for adults and/or children.

1. Examine the feasibility of establishing sub acute crisis stabilization and supervised residential services for children and adults.

a. Explore the need for statutory or regulatory changes that would provide for or allow locked or otherwise controlled residential facilities.

Goal #5 Study ways to enhance private/public coordination of care.

1. Formalize service access structure and communication processes to provide collaboration that is necessary to ensure that bureaucratic systems to not impede access to appropriate services.

Recommendations for State Level Actions:

1. The Regional Strategic Planning Partnership adopted a goal of prioritizing population groups and working toward uniform service availability across jurisdictions. Region IV proposes to use additional regional and local funding to move in this direction.

2. Certain benefits and services should be universal. When and if additional resources become available, a second level of services could be implemented. A third level of services may be created when localities use their local tax dollars to support certain services.

3. The State should adequately fund a minimum level of services to assure constituent services throughout the region.

4. DMHMRSAS needs to work with the Department of Medical Assistance Services so that Medicaid supports services that MH deems essential for recovery. Medicaid must be revamped to become more flexible.

5. The services system must be responsive to the need of persons who have Medicaid as a payer as well as those who do not.

6. DMHMRSAS should seek simplification in administrative processes and reporting.

7. The system needs a more coordinated approach at the State level, on that supports a single vision for a system of care.

8. DMHMRSAS leadership is essential in defining short-and long-term role of State facilities.

9. Facilities should be encouraged to put in practice reinvestment and restructuring concepts that complement and support those in the local system.